		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155210	A. BUILDING	00	COMPLETED 03/29/2011	
		133210	B. WING		03/29/2011	
NAME OF I	PROVIDER OR SUPPLIE	₹	I	ADDRESS, CITY, STATE, ZIP CODE RK ROAD		
HERITAC	GE HOUSE OF GR	EENSBURG	I	NSBURG, IN47240		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE	
	REGULATORY OR	LISC IDENTIFY ING INFORMATION)	TAG	DEFICIENCE)	DATE	
F0000	(PSR) to the Rec Licensure Surve Survey Dates: M Facility number: Provider number: AIM number: 1 Survey team: Diana Sidell RN Janie Faulkner F Census bed type SNF/NF: 70 Total: 70 Census payor ty Medicare: 6 Medicaid: 43	r: 155210 00266460 T, TC RN	F0000	Please accept this Plan of Correction as allegation of the deficiencies noted in the 2567 Heritage House of Greensbur In submitting this Plan of Correction, Heritage House is admitting to the allegations of non-compliance contained with	r for g. not	
	Other: 21					
	Total: 70					
	Sample: 9					
		es also reflect state accordance with 410 IAC				
F0223	The resident has	4/11 by Suzanne Williams, RN the right to be free from hysical, and mental abuse,				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

U85D12

Facility ID:

000117

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3		X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155210	B. WIN			03/29/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			410 PAI	RK ROAD		
	GE HOUSE OF GRE	EENSBURG		GREEN	ISBURG, IN47240		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	seclusion.	ent, and involuntary					
SS=D	sexual, or physica punishment, or inv	not use verbal, mental, I abuse, corporal voluntary seclusion. review and interview, the	F0	223	It is the practice of this facility		04/28/2011
SS=D	facility failed to had hypersexual and to prevent reabuse for 1 of 1 habuse in a sample. Findings include A policy and pro Alleged Abuse", February 2008, v. Director of Nursep.m. The policy limited to: "PUF	identify a resident who behaviors (resident #91) sident to resident sexual resident reviewed for e of 9. (Resident #90) : cedure for "Incidents of with an initial date of was provided by the ing on 3/28/11 at 4:02 indicated, but was not RPOSE: To ensure that free of physical, mental,	F0	223	It is the practice of this facility keep all resident free form veri sexual, physical and mental abuse, corporal punishment an involuntary seclusion. Residen 90 has not demonstrated any negative outcome from this episode regarding resident #9 Resident #90 has NOT been to recipient of any episodes since this isolated incident. Resident #90 now has a lap throw blank over her while up in chair due the nature of which resident #9 had put is his hand between he fully clothed legs. Resident #9 does not have the ability to control movements or position due to diagnosis of Huntington chorea. A stop sign mesh barr is placed across the doorway of	bal, nd tt # o1. he e set to o1 ing i's ier	04/28/2011
	punishment, mer and involuntary s Residents residing treated with dign accordance with They will not be mental, verbal ar punishment, mer and involuntary seclusionPREV TION OF POTE	atal and physical neglect, seclusion. POLICY: ag in this facility will be ity and respect in their individual needs. subjected to physical, ad sexual abuse, corporal atal and physical neglect, VENTION/IDENTIFICA NTIAL ABUSE: schibit abusive behavior:			her room and has an alarm the sounds if the barrier is remove or walked through. If for some reason upon re-evaluation of t it is ineffective a motion senso alarm will be trialed. All other residents in this facility have the potential to be affected by this defiant practice, however no or resident has been affected. To continuous process of evaluations, observation, education and auditing of residents will continue Staff and families will be conducted to	at d his r ne ther he	

X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155210 03/29/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 410 PARK ROAD HERITAGE HOUSE OF GREENSBURG GREENSBURG, IN47240 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX COMPLETION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Ensure that all residents with a significant ensure all are free from abuse. This will be done by:1) history of aggression have been assessed Completing a thorough and care plan interventions documented to pre-admission assessment of any provide staff with appropriate potential residents and if identified as a possible threat to information." other residents in any manner it will be determined if the facility 1. Resident #91's record was reviewed on can meet the needs of the 3/28/11 at 1:15 p.m. The record indicated resident AND keep others free resident #91 was admitted with diagnoses from ANY form of abuse. If the facility does not feel it can that included, but were not limited to, accomplish this then the resident bipolar disorder, dementia, cognitive will be denied admission. If the impairment, depression, insomnia, facility determines it CAN meet paranoid schizophrenia, and hypersexual the needs of the resident we will measures in place to ensure the behavior. safety of other residents. Should facility admit resident with history An admission minimum data set of sexual behavior, it will be noted in the care plan upon admission. assessment, dated 1/24/11, indicated Appropriate interventions will be resident #91 was moderately cognitively noted immediately with impaired, was able to make himself appropriate preventions in place understood, usually understands others, at time of admission. This will be re-evaluated with each potentially and ambulated with a rolling walker threatening resident. It will be without assistance. discussed with department heads, specifically D.O.N. and A "Preadmission Screening and Resident Social Service Director but Review (PASRR)" dated 1/14/11 ultimately the decision of the Administrator.2) If a resident has indicated resident #91 was ambulatory, a known history of abusive used a wheelchair or walker, was behaviors the facility will ensure confused/disoriented, had primary the resident is seen by the proper diagnoses of dementia, paranoid discipline i.e. The Psychologist and mental health professionals. schizophrenia, hypersexual behavior, and The facility will follow the depression, and needed 24 hour recommendations of these supervision and assist with activities of professionals and notify them daily living. immediately if medications or other interventions are

MAME OF PROVIDER OR SUPPLER HERITAGE HOUSE OF GREENSBURG (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) SUMMARY STATEMENT OF DEFICIENCIES (X6) REPERT RECELLATION OR LEDERITHYRIA DINORMATION) A medical record discharge summary, dated 1/14/2011, from a hospital visit indicated: "RFASON FOR ADMISSION: DEMENTIA NH (NURSING HOME) PLACEMENTPRIMARY DIAGNOSIS (Diagnosis or condition that was treated): 1. Hypersexual behavior/ depression 2. Dementia (Alzheimers versus mixed)PERITINENT HISTORY AND PHYSICAL INDINORS: Pt (patien)h/o (history of) dementia/cognitive impairmentparanoid schizophrenia, CKD (chronic kidney disease), depression, and prostate cancer who was brought in by (family member) last noticed increasing sexual proccupation for the past six months and pt has become sexually aggressive towards female employees and residents at his current ECF (extended eare facility). Pt reportedly grabbed another female resident's chest two weeks ago, and was sent to [psych hospital] where he was hospitalizedthen transferred back to his ECF and given a "second chance". Tornight, however, pt was caught kissing the same female resident, and pt was "kisced out" of the facility. Pt currently alert and is able to describe the incident in detail, but he failis to see "what the big deal is" and, pt reports other ECF resident ### STRUCTATION TRANS (ITP, STATE, JPP CODIES. TOPPINGES FLAVOR ORD PREPIX 10 PREPIX 1	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
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deal is" and, pt reports other ECF resident at least 10% of the residents on a		detail, but he fail	s to see "what the big			be done on a random sample	of	
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155210	B. WIN			03/29/2	011
		I			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			RK ROAD		
HERITA	GE HOUSE OF GRE	EENSBURG		1	ISBURG, IN47240		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
	1	rticipant. ECF transfer			monthly basis indefinitely. 7)		
	records also repo	ort hx (history) of pt			results of the Quality Assurance Tool audits and Behavior Meet		
	inappropriately g	grabbing self in front of			will be presented to the Quality	•	
	female staff"				Assurance Committee and any		
					recommendations made will be		
	Social Service N	lotes dated 1/23/11			followed. Resident #91 has ha	d	
		nission assessment			the following adjustments or		
		& on chart. Has adjusted			interventions to prevent him fro		
		ing facility) & staff. D/T			any further sexual advances in the futureDepakote ER 250m		
	,	• • •			HS 3/24/11-Depovera 150mg	•	
	· ′	2/15 on depression scale -			2weeks IM 3/29/11 -Decrease		
		nursing) obtain order for			Lexapro to 10 mg qd on 04/07		
	res. (resident) to	see [psychologist]. DNR			per psychologist		
	(do not resuscita	te) code status & no			recommendationEvery 15mir	nute	
	current plan for	D/C (discharge). No			visual checks done and	.4-	
	sexual behaviors	noted. Will cont[inue]			documented on his whereabou until determined by IDT that it		
	to observe, asses	ss & meet res. needs."			no longer necessary-Behavior		
	,				tracker continued, care plan		
	Nurse's notes da	ted 3/15/11 at 12:50 p.m.			initiated and revised. A 1:1		
		pprox[imately] 12:30			discussion with Resident #91		
		l res[ident] in hallway,			regarding inappropriate vs.		
	_				appropriate behavior. Instruction resident he is not to enter other		
	1	MDR (main dining			residents' rooms uninvited-On		
	· · · · · · · · · · · · · · · · · · ·	ed she said "hi" to him.			3/28/11 The V.A. Hospital		
		more room & asked			evaluated resident #91 for		
		mber what he was doing.			behaviors and psych issues ar		
		nember stated to get			opted not to admit him, deemii	ng	
	[resident #91], h	e just went into her room.			him safe and appropriate to	hor	
	CNA turned & in	mmediately went to			return to nursing facility with of dependent residentsThe MD		
	female's room.	As she approached, she			Pharmacist, Psychologist, and		
	called out his name. He turned. She noticed female sitting in her chair, fully clothed with [resident 91's] hand between female's fully clothed legs. She told res to stop. CNA approached & removed his				facility Behavior Management		
					Team have all reviewed the		
					resident in all aspects are		
					confident the resident is safe t remain at the facility. His	U	
					Depovera is NOW noted NOT	to	
	1 1				be discontinued or have an		
	hand away from	female. Explained not			be discontinued or have an		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155210	A. BUI	LDING	00	03/29/2011
		133210	B. WIN			03/29/2011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE RK ROAD	
HFRITA(GE HOUSE OF GRE	FNSBURG			ISBURG, IN47240	
(X4) ID		TATEMENT OF DEFICIENCIES		ID		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
	appropriate. CN.	A escorted him out of			interuption of therapy unless	
	female's room. I	He went on to dining			specifically ordered by MD to	
	room to eat lunch	1"			so and why. Deprovera is kno to be proven to be effective in	ow
					surpressing the sexual	
	Social Service No	otes dated 3/15/11			desires. All of this has been or	will
		was observed by CNA			be completed by 4/28/11.	
] going into res. room				
	1	Vhen CNA [#1] entered				
	· -	90's room number]she				
		. [with] hand between				
	legs of res. [#90]					
		es. (#91) away from				
		& out of room. This				
		ned of this by chg. nurse,				
	1 1	When writer went to				
	1 * * *	A [#1] writer walked past				
		[#90] & observed her brway in w/c in inapprop.				
		res. chart SS (Social				
	I	5/11). This res. has had				
	1	prop. behaviors in this NF				
		, CNA's & this writer's				
		never entered another				
	res. room"					
	A "Facility Incide	ent Reporting Form"				
		licated the preventive				
	measures taken v	vere: "[Resident #91]				
	will continue to b	be followed by				
	[psychologist]. [Resident #91] will be				
		ogist] at his next visit.				
		tion review on [Resident				
	1	#91 does not have a				
	history of going i	into other resident's				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	155210	- 1	LDING	00	03/29/2	
		133210	B. WIN		PRESIDENCE CONTROL CON	03/23/20	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE RK ROAD		
HERITAC	GE HOUSE OF GRE	EENSBURG		1	ISBURG, IN47240		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		r, if he is noted going into					
		ooms uninvited, he will					
	~	leave. [Resident #91]					
	has not had any p	previous episodes of					
	inappropriate sex	tual behaviors at our					
	facility. [Residen	nt #90] wears pants at all					
	times, which we	will continue to do. Will					
	ask [Resident #9	0's] family about the					
	possibility of mo	ving her to a different					
	room or rearrang	ing her room somewhat					
	due to her body p	positioning. Care plans					
	will be updated."						
	_						
	On 3/28/11 at 4:0	05 p.m., the Director of					
		d she was not sure if they					
	_	1 had any behaviors					
		but they knew he had					
	dementia.						
	On 3/28/11 at 4:1	10 p.m., the Social					
		indicated she was not					
		avior [hypersexual] until					
		resident #90, but knew					
		ree other facilities before					
	admission here.	ree office facilities octore					
	administration note.						
	On 3/29/11 at 4·1	18 p.m., the Director of					
		d resident #91 had no					
	behavior care pla						
	_	ney had put the current					
		in in place after the					
	incident on 3/15/						
	meiuent on 5/15/	11,					
	2. Resident #90'	s record was reviewed on					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155210	B. WIN			03/29/2	011
NAME OF A				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	C		410 PAI	RK ROAD		
	GE HOUSE OF GRE				ISBURG, IN47240		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCE		DATE
		p.m. The record					
		nt #90 was admitted with					
		cluded, but were not					
	limited to, depre	_					
		ease, expressive aphasia					
	(cannot speak), a	and rigidity.					
	A quarterly mini	mum data set assessment					
		dicated resident #90 was					
		vely impaired, had no					
	speech, did not r						
	1 *						
	1	as totally dependant on					
	staff for all care.						
	 Social Service N	lotes dated 3/15/11 (no					
		d) indicated: "Res. does					
		ve any adverse reaction to					
		volving male res. This					
	1	SDH d/t sexually					
		-					
		This writer observed this					
	_	e in her room, facing					
		legs in contracted [up]					
		sition & spread apart (as					
		itioning for res. d/t ES					
	1 ' ' '	ington's). Res. was fully					
	clothed however	, no lap blanket on. Lap					
	blanket was plac	ed on res. & she was					
	positioned away	from doorway, facing					
	T.V. Res. [with] ES Huntington's, does						
	not speak, makes no decisions for self &						
	_	all ADL's. Does not					
	_	ecall that male res. was in					
	room"	· · · · · · · · · · · · · · · · · · ·					
	I .						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155210	1			03/29/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			l			
LEDITA C	SE HOUSE OF GRE	ENCOLIDO		l	RK ROAD		
HERITAG	SE HOUSE OF GRE	ENSBURG		GREEN	ISBURG, IN47240		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re l	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	3.1-27(a)(1)						
F0226	,	levelop and implement					
		d procedures that prohibit					
		lect, and abuse of residents					
		ion of resident property.					
SS=D		review and interview, the	F0	226	It is the practice of this facility		04/28/2011
	facility failed to	implement the abuse			keep all resident free form verl sexual, physical and mental	oai,	
	prohibition polic	y and procedure related			abuse, corporal punishment ar	nd l	
	to prevention and	d identification of			involuntary seclusion. Residen		
	-	or one resident admitted			#90 has not experienced and	.	
	•	of hypersexual behavior			negative outcomes from this		
	•	This affected 1 of 1			deficient practice and has bee	n	
	` ,				addressed as stated in F 223 (
		d for abuse in a sample of			this plan of correction. Resider	nt	
	9. (Resident #90))			#91 has had the following		
					adjustments or interventions to prevent him from any further	'	
	Findings include				sexual advances in the future.		
					-Depakote 250mg HS		
	A policy and pro-	cedure for "Incidents of			3/24/11-Depovera ER 150mg	q 2	
		with an initial date of			weeks IM 3/29/11 -Decreased		
	_	vas provided by the			Lexapro to 10 mg qd on 04/07	11	
	-	ing on 3/28/11 at 4:02			per psychologist		
		•			recommendationEvery		
		indicated, but was not			15minute visual checks done a documented on his whereabou	-	
		RPOSE: To ensure that			until determined by IDT that it		
	each resident is f	ree of physical, mental,			no longer necessary-Behavior		
	verbal and sexua	l abuse, corporal			tracker implemented, care plan		
	punishment, men	ital and physical neglect,			initiated and revised. A 1:1		
	•	seclusion. POLICY:			discussion with Resident #91		
	-	g in this facility will be			regarding inappropriate vs.		
	treated with dign	•			appropriate behavior. Instruction	-	
	_	their individual needs.			resident he is not to enter othe residents' rooms uninvited-On		
					3/28/11 The V.A. Hospital		
	_	subjected to physical,			evaluated resident #91 for		
	· ·	nd sexual abuse, corporal			behaviors and psych issues ar	nd	
	punishment, men	atal and physical neglect,			opted not to admit him, deemir		
	and involuntary				him safe and appropriate to	·	
			1		return to nursing facility with of	ther	

li ´		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155210	B. WIN			03/29/2	011
NAME OF	DD OLUDED OD GLIDDLIEF			STREET A	ADDRESS, CITY, STATE, ZIP CODE	!	
NAME OF	PROVIDER OR SUPPLIEF	C		410 PA	RK ROAD		
	GE HOUSE OF GR				NSBURG, IN47240		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		VENTION/IDENTIFICA			dependent residentsThe MD Pharmacist, Psychologist, and		
	TION OF POTE	NTIAL ABUSE:			facility Behavior Management		
	Residents who e	xhibit abusive behavior:			Team have all reviewed the		
	Ensure that all re	esidents with a significant			resident in all aspects are		
	history of aggres	ssion have been assessed			confident the resident is safe t	О	
		erventions documented to			remain at the facility. His		
	provide staff wit				Depovera is NOW noted NOT	to	
	information."	парргориас			be discontinued or have an		
	illioillation.				interuption of therapy unless specifically ordered by MD to	40	
					so and why. Deprovera is known		
		s record was reviewed on			to be proven to be effective in	,,,,	
	_	o.m. The record indicated			surpressing the sexual		
	resident #91 was	admitted with diagnoses			desires. All other residents in	his	
	that included, bu	t were not limited to,			facility have the potential to be		
	bipolar disorder,	dementia, cognitive			affected by this defiant practic		
	_	ression, insomnia,			however no other residents ha		
		ohrenia, and hypersexual			been affected. The continuou	S	
	behavior.	mema, and hypersexual			process of evaluations, observation, education and		
	ochavior.				auditing of residents will contin	nue.	
					Staff and families will be		
	An admission m				conducted to ensure all are fre	ee	
		d 1/24/11, indicated			from abuse.This will be done		
		moderately cognitively			by:1) Completing a thorough		
	impaired, was at	ole to make himself			pre-admission assessment of	any	
	understood, usua	ally understands others,			potential residents and if identified as a possible threat	to	
	and ambulated w	ith a rolling walker			other residents in any manner		
	without assistance	ce.			will be determined if the facility		
					can meet the needs of the		
	A "Preadmission	Screening and Resident			resident AND keep others free		
	Review (PASRR	· ·			from ANY form of abuse. If the	•	
	· `				facility does not feel it can	ont	
	1	nt #91 was ambulatory,			accomplish this then the resid- will be denied admission. If the		
	used a wheelcha				facility determines it CAN mee		
		nted, had primary			the needs of the resident we w		
	diagnoses of den	nentia, paranoid			measures in place to ensure the		
	schizophrenia, h	ypersexual behavior, and			safety of other residents. Sho	uld	
	depression, and	needed 24 hour			facility admit resident with hist	ory	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155210 03/29/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 410 PARK ROAD HERITAGE HOUSE OF GREENSBURG GREENSBURG, IN47240 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE of sexual behavior, it will be noted supervision and assist with activities of in the care plan upon admission. daily living. Appropriate interventions will be noted immediately with A medical record discharge summary, appropriate preventions in place at time of admission. This will be dated 1/14/2011, from a hospital visit re-evaluated with each potentially indicated: "REASON FOR threatening resident. It will be ADMISSION: DEMENTIA NH discussed with department (NURSING HOME) heads, specifically D.O.N. and PLACEMENT...PRIMARY DIAGNOSIS Social Service Director but ultimately the decision of the (Diagnosis or condition that was treated): Administrator.2) If a resident has 1. Hypersexual behavior/ depression 2. a known history of abusive Dementia (Alzheimers versus behaviors the facility will ensure mixed)...PERTINENT HISTORY AND the resident is seen by the proper discipline i.e. The psychologist PHYSICAL FINDINGS: Pt (patient)...h/o and mental health professionals. (history of) dementia/cognitive The facility will follow the impairment...paranoid schizophrenia, recommendations of these professionals and notify them CKD (chronic kidney disease), immediately if medications or depression, and prostate cancer who was other interventions are brought in by [family member] after being ineffective.3) The facility will "kicked out of his nursing home"...Per pt's implement the behavior records, [family member] has noticed monitoring form and tracking methods for any existing or new increasing sexual preoccupation for the abusive behaviors. These will be past six months and pt has become dealt with immediately if any sexually aggressive towards female occurrences otherwise the employees and residents at his current behaviors will be summarized and documented on a monthly basis, ECF (extended care facility). Pt prn and with each care plan reportedly grabbed another female conference for effectiveness.4) resident's chest two weeks ago, and was The Consultant Pharmacist will sent to [psych hospital] where he was review all medications monthly. The interdisciplinary team hospitalized...then transferred back to his (including psychology, ECF and given a "second chance". pharmacy, social service and Tonight, however, pt was caught kissing nursing) will evaluate medications the same female resident, and pt was and side effects monthly also they will follow up on any pharmacist, "kicked out" of the facility. Pt currently

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

U85D12 Facility ID:

000117

If continuation sheet

Page 11 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155210		LDING	00	03/29/2	
		100210	B. WIN		ADDRESS CITY STATE ZIR CODE	00/20/2	011
NAME OF	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP CODE RK ROAD		
HERITA	GE HOUSE OF GR	EENSBURG		1	ISBURG, IN47240		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAU		to describe the incident in		IAG	mental health consultant		DATE
	1	ls to see "what the big			recommendations, notify		
	1 '	eports other ECF resident			Physician as well as process		
	1	rticipant. ECF transfer			orders and interventions included updating the plan of care.5) A		
	1	ort hx (history) of pt			staff will be educated on the	.11	
	_	grabbing self in front of			proper policy and procedure to)	
	female staff"	5.400 mg own in mont or			prevent/report abuse including	'	
					sexual abuse and the measure to take if it does occur. This wi		
	Social Service N	lotes dated 1/23/11			be conducted now and then		
	1	nission assessment			quarterly thereafter.6) The		
	complete today	& on chart. Has adjusted			behavior monitoring Quality	200	
	1 ^ *	ing facility) & staff. D/T			Assurance/Improvement tool (Attachment) will be done on al		
	`	2/15 on depression scale -			residents by 4/28/11, and then		
	will have nrsg. (nursing) obtain order for			be done on a random sample		
	res. (resident) to	see [psychologist]. DNR			at least 10% of the residents of monthly basis indefinitely. 7)		
	(do not resuscita	te) code status & no			results of the Quality Assurance		
	current plan for	D/C (discharge). No			Tool audits and Behavior Meet	•	
	sexual behaviors	noted. Will cont[inue]			will be presented to the Quality Assurance Committee and any		
	to observe, asses	ss & meet res. needs."			recommendations made will be		
					followed. The completion dat		
	1	ted 3/15/11 at 12:50 p.m.			for this is 4/28/11		
	1	pprox[imately] 12:30					
	1 ^	l res[ident] in hallway,					
	"	MDR (main dining					
	1 '	ed she said "hi" to him.					
	1	more room & asked					
	1	mber what he was doing.					
	1	nember stated to get					
	1	e just went into her room.					
		mmediately went to					
		As she approached, she					
	1	me. He turned. She					
		itting in her chair, fully					
	clothed with [res	sident 91's] hand between					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155210	B. WIN			03/29/2	011
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	R		410 PAI	RK ROAD		
	GE HOUSE OF GRI				ISBURG, IN47240		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	1	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG		· · · · · · · · · · · · · · · · · · ·	-	TAG	Berielekery		DATE
	1	othed legs. She told res to					
	1	oached & removed his					
	1	female. Explained not					
		IA escorted him out of					
	1	He went on to dining					
	room to eat lunc	h"					
	Social Service N	Notes dated 3/15/11					
	1	was observed by CNA					
		2] going into res. room					
	1	When CNA [#1] entered					
	1	90's room number]she					
	1 -	s. [with] hand between					
	legs of res. [#90]						
	1 -	res. (#91) away from					
	1	•					
		& out of room. This					
	1	med of this by chg. nurse,					
	1 -	When writer went to					
		A [#1] writer walked past					
		[#90] & observed her					
	sitting facing do	orway in w/c in inapprop.					
	1 * `	res. chart SS (Social					
	Service) note 3/1	15/11). This res. has had					
	no sexually inap	prop. behaviors in this NF					
	& per chg. nurse	e, CNA's & this writer's					
	observations has	s never entered another					
	res. room"						
	A "Facility Incid	lent Reporting Form"					
	I -	dicated the preventive					
	measures taken were: "[Resident #91]						
	will continue to						
		[Resident #91] will be					
		logist] at his next visit.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPLI		
AND PLAN	OF CORRECTION	155210	A. BUI		00	03/29/20	
		100210	B. WIN		ADDRESS CITY STATE ZID CODE	00/20/20	711
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE RK ROAD		
HERITAC	GE HOUSE OF GRE	ENSBURG		1	ISBURG, IN47240		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)	-	TAG	DETCIENCT)		DATE
		tion review on [Resident					
	1	#91 does not have a					
	, , ,	into other resident's					
		r, if he is noted going into					
		ooms uninvited, he will					
	1	leave. [Resident #91]					
	1	previous episodes of					
	1 ^^ ^	tual behaviors at our					
	I	nt #90] wears pants at all					
		will continue to do. Will					
		O's] family about the					
	1 -	ving her to a different					
	ı	ing her room somewhat					
	1	positioning. Care plans					
	will be updated."						
	On 3/28/11 at 4:0	05 p.m., the Director of					
		d she was not sure if they					
		1 had any behaviors					
		but they knew he had					
	dementia.	out they knew he had					
	delitering.						
	On 3/28/11 at 4:1	0 p.m., the Social					
		indicated she was not					
		avior [hypersexual] until					
		resident #90, but knew					
		ree other facilities before					
	admission here.						
	On 3/29/11 at 4:1	8 p.m., the Director of					
		d resident #91 had no					
	behavior care pla	n in place after					
	admission, and th	ney had put the current					
	behavior care pla	n in place after the					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	PROVIDER/SUPPLIER/CLIA (X2) MUI		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		BUILDING 00			COMPLETED	
		155210	B. WING			03/29/2011		
					ADDRESS, CITY, STATE, ZIP CODE	l		
NAME OF F	PROVIDER OR SUPPLIER			410 PA	RK ROAD			
HERITAGE HOUSE OF GREENSBURG			GREENSBURG, IN47240					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	CROSS-REFERENCED TO THE APPROPRIATE		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX			COMPLETION	
IAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		+	TAG			DATE	
	incident on 3/15/	incident on 3/15/11.						
	2. Resident #90's record was reviewed on							
	3/28/11 at 12:45 p.m. The record							
	indicated resident #90 was admitted with							
	diagnoses that included, but were not							
	limited to, depression, end stage							
	Huntington's disease, expressive aphasia							
	(cannot speak), and rigidity.							
	A quarterly minimum data set assessment							
	dated 3/20/11 indicated resident #90 was							
	severely cognitively impaired, had no							
	speech, did not recognize family							
	members, and was totally dependant on							
	staff for all care.							
	stan for an care.							
	Social Service Notes dated 3/15/11 (no							
		l) indicated: "Res. does						
		e any adverse reaction to						
	incident today involving male res. This							
	was reported to ISDH d/t sexually							
	inapprop[riate]. This writer observed this							
	res. sitting in w/c in her room, facing							
	doorway [with] legs in contracted [up]							
	ben @ knees position & spread apart (as							
	this is norm. positioning for res. d/t ES							
	(end stage) Huntington's). Res. was fully							
	clothed however, no lap blanket on. Lap							
	blanket was placed on res. & she was							
	positioned away from doorway, facing							
	T.V. Res. [with]	ES Huntington's, does						
	not speak, makes	no decisions for self &						
	is dependent for	all ADL's. Does not						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155210		(X2) MULTIPLE CC A. BUILDING B. WING	00	COM	(X3) DATE SURVEY COMPLETED 03/29/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK ROAD GREENSBURG, IN47240					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	appear to even re	ecall that male res. was in						
	3.1-28(a)							